DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 25 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING ______ B. WING ______	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based of record review, staff interviews, the facility failed to report 3 of 3 allegations of sexual abuse reported by 1 of 1 cognitively impaired resident (Resident #59). The findings include: Record review of the undated facility policy titled "Abuse Prevention" read in part "G. Report and Response The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to law enforcement officials as designated by state law." Record review of the facility policy titled "Policy & Procedure for Reporting Suspected Crimes Under the federal Elder Justice Act" read in part "It is the facility policy to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicious of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA), 6703(b) (3). Specifically, it is the facilities policy to:	F 226	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiency exists and/or was correctly cited or required correction.** 1. Resident # 59 made no further allegations of forced sexual encounters prior to readmission to previous assisted living facility. 2. All current resident charts who have been seen by Paradigm in last 90 days, and all admissions with current behavior plans related to possible sexual acting out were audited on 9/27/11. 3. The Administrator and Director of Nursing were in-serviced by the VP of Clinical Services on Abuse investigation, prevention and reporting and on reporting of suspected crimes on 9/26/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: administrator (X6) DATE: 10/21/

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 Report and will assist covered individuals in reporting a suspected crime against a resident to the local law enforcement entities." Resident # 59 was admitted to the facility on 07/26/11. The residents' cumulative diagnoses include Depressive Disorder, Altered Mental Status, Personality Disorder, Atypical Psychosis and Mental Retardation. The resident ' s Admission Minimum Data Set (MDS) assessment dated 08/03/11 revealed that the resident short and long term memory is impaired and she is moderately impaired for decision making skills. 1. Record review of the Nurse's Notes for Resident #59 dated 08/25/11 (late entry) written by the Nurse on the hall (Nurse#5) indicated that the resident approached the Nurse at 1830 and stated "Mama, that man took me into shower, put his hands over my mouth and put his thing in me." When asked who "that man" was, resident pointed to another resident in geri chair. Will make supervisor aware. Right after she made this comment, noted laughing and talking with other residents. Alert to person. During an interview on 09/28/11 at 11:30 AM Nurse #5 indicated that Resident #59 approached her at the end of her shift and stated "Mama, that man over there took me to the shower, put his hand over my mouth and put his thing in me." Resident #59 pointed to Resident #106 as the man who did it, when asked who the man was. Nurse #5 indicated that Resident #106 is a total ADL resident who sits in a geri chair with a self release belt that alarms when released. Nurse #5 indicated that she reported the incident to the	F 226	All staff was in-serviced by the Administrator on abuse investigation and reporting and reporting of suspected crimes on 10/10/11. Education also included documentation and notification of change in resident behavior or noted distress and immediate reporting of any allegation of sexual abuse. Monitoring will be done through: Use of the 24-hour clinical report with documentation of any resident distress or change in behavior. This report will be reviewed in the morning clinical meeting with the interdisciplinary team. 4.. Compliance will be discussed at the QA meeting monthly for 6 months and then quarterly.	10/20/[illegible]

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F 226	Continued From page 2 Acting Director of Nursing at that time and is no longer employed at the facility. Review of the past reported abuse allegations indicate the facility did not report this allegation of sexual abuse to local law enforcement. 2. During an interview on 09/29/11 at 10:43 AM the Activity Director indicated that on 09/07/11 she was doing an individual activity with Resident #59 and she said I got something to tell you. The Resident stated "a man (Resident #121) came to her room and put his thing in her." The Activity Director indicated stated that she took the Resident immediately to the B-Hall Nurse (#6). Record review of the Nurse's Notes for Resident #59 dated 09/07/11 written by the Nurse on the hall (Nurse#6) indicated that the Activities Director brought pt. (patient) to this nurse. Pt. stated that "that man pushed her legs apart and put his finger in me then put that thing in me." Pt.'s diaper is still intact. Pt. has made this accusation in the past. She has had a psych consult and will see psychiatrist on next visit. Review of the past reported abuse allegations indicated that Nurse #6 did not report this allegation of abuse. Review of the past reported abuse allegations indicate the facility did not report this allegation of sexual abuse to local law enforcement. 3. Review of Social Service Progress Notes dated on 09/27/11 for resident #59 written by the Social Worker read in part " Nursing and activities director informed Social Worker (SW)	F 226		

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F 226	Continued From page 3 that client is stating the same male resident stole her money. Resident reported the following to staff "he came in my room open my drawer and took 3 quarters, then he took me and my roommate wheeled us to the bathroom and punched me in my chest and stuck his penis in me, he then called me a "_____ & _____" , I told him he needed to wear a condom before having sex." SW asked resident did she try to stop him, resident replied "no." During an interview on 09/28/11 at 10:35 AM the facility Administrator indicated that the facility has came up with a critical action plan for abuse as a result of the incident reported on 09/23/11 for resident #59. The Administrator stated after chart review it was noted that there were two other abuse incidents that were not reported. Administrator stated that because of repeated verbalization about rape it was determined this was not a credible allegation and the facility did not call the police. The Administrator further stated that the facility would be working closely with the Harnett County police department to determine if this is a behavior and how the facility can follow the guidelines and protect the resident. During and interview on 09/29/11 at 9:30 AM with the Sergeant from the Harnett County police department who is investigating this incident indicates that the case is still open and based on the information he has gathered thus far indicates that the resident was not raped. During and interview on 09/29/11 at 1:50 PM the Director of Nursing (DON) indicated that the resident reported to her on 09/23/11 that she was sexually assaulted by a male resident. Per the	F 226		

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F 226	Continued From page 4 DON she immediately assessed the resident and there was no bruising, redness and other signs of being sexually assaulted. The DON stated that she did not call the police because she did think it was not a credible allegation. During and telephone interview on 10/11/11 at 9:30 AM with the Sergeant from the Harnett County police department who is investigating this incident indicated that no one from the facility called in this allegation of sexual abuse. The Sergeant further stated that the incident was reported on 09/26/11 from an outside source. The Sergeant stated that it is his expectation that the facility follow their policy.	F 226		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	1.Resident # 45 is receiving medications as ordered by the Physician. 2. Residents with Physician's orders for medications that require a prescription for refill may be affected. All current refill medication requests requiring physician response were audited on 9/29/11. 3. Measures/systems in place to ensure continued compliance are:	

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F 425	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and pharmacist interview, the facility failed to ensure the physician responded promptly to refill requests, resulting in medication being unavailable, for 1 of 10 residents whose medications were reviewed (resident #45). Findings include: Resident #45 was admitted 5/13/10 and readmitted 8/20/11 with multiple diagnoses including anxiety and insomnia. Review of the resident's clinical record revealed physician orders dated 1/11/11 for Xanax (alprazolam) 0.25mg (milligram) every night at bedtime. Xanax is indicated for the treatment of anxiety and has an off-label (non-FDA approved) indication for insomnia. Xanax is a schedule 4 controlled drug. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "taper dosage slowly; do not discontinue abruptly." Review of the resident's July 2011 medication administration record (MAR) revealed the nurse's initials were circled on 7/13/11 through 7/20/11, indicating the Xanax was not given on those days. Review of the nursing notes and the MAR revealed no explanation for the resident's Xanax not being given. In an interview on 9/29/11 at 10:20AM, nurse #2	F 425	The Administrator and Director of Nursing have reviewed the importance of providing prescriptions in a timely manner with the facility Medical Director on 10/19/11 Nurses will fax a reminder to the Physician 7 days prior to the refill date for medications that require a prescription. The medication nurse and/or nurse supervisor will contact the DON and/or Administrator if the physician fails to respond to the request on a timely basis to ensure that medications are not missed. The DNS or designee will review the Medication Administration record and Narcotic count sheets weekly X 4 Weeks, bi-monthly x 4 weeks, then monthly x 4 months.	

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F 425	Continued From page 6 stated the pharmacy delivered once daily at night. The policy was to call the pharmacy if a medication was out. The pharmacy would send out the medication immediately or call the local backup pharmacy. Nurse #2 reviewed the resident's MAR and stated if the nurse's initials were circled, it meant the medication was not given. He stated the nurse should have written an explanation for the omitted doses of medication on the MAR or in the nursing notes. Nurse #2 stated it may have taken longer to get the Xanax refilled since it was a controlled drug and the pharmacy needed a written prescription from the physician. Nurse #2 stated he worked the day shift and was not aware that the resident had not received the Xanax. He added "it shouldn't have taken 8 days to get the prescription from the physician." In a telephone interview on 9/29/11 at 2:45PM, the Pharmacy Manager stated the pharmacy delivered daily and had local backup pharmacies in the area to meet the facility's needs. He stated there was at least a 2-3 day turnaround for refills, even longer for controlled medications since the pharmacy must have a written prescription signed by the physician. He acknowledged resident #45 had not received her Xanax from 7/13/11 - 7/20/11. He stated it was difficult to get in touch with her physician. The pharmacy staff had called and faxed the physician daily. Messages were left at his office with no response. The Pharmacy Manager indicated this had been an ongoing problem with this physician. He stated the facility's administrator and corporate Medical Director had talked to the physician numerous times about not responding timely to refill requests from the pharmacy.	F 425	The pharmacist will notify the DON & Administrator of any issue that may result in the resident not receiving a medication timely found during monthly consultant chart review. 4. Findings will be reviewed in the monthly QA meeting for 6 months and then quarterly.	10/21/11

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F 425	Continued From page 7 In an interview on 9/29/11 at 4:05PM, the Director of Nursing (DON) stated getting a timely response from the physician for refill requests had been an ongoing issue. She had not talked to the physician regarding resident #45's Xanax since she wasn't employed at the facility at that time. The DON stated she had talked to the physician about responding to refill requests for other residents. The DON stated she had contacted her corporate Medical Director to assist in resolving the issue. The DON stated she expected the physician to facilitate orders in a timely manner to ensure residents received their medications as ordered. The resident's evening nurse on duty 7/13/11 - 7/20/11 was not available for interview.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	1. The undated PPD/tuberculin vial was removed from the medication refrigerator and destroyed on 9/29/11 2. Residents newly admitted to the facility and residents scheduled for annual tuberculin testing may be affected. Medication room, refrigerators, & carts were examined for proper labeling of multi-dose vials.	

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F 431	Continued From page 8 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to date a multiple dose vial of a diagnostic agent for tuberculosis when opened for 1 of 1 medication rooms. Findings include: The facility policy, undated, titled Preparation for Medication Administration, read in part "vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations...the date opened and the initials of the first person to use the vial are recorded on multi-dose vials (on the vial label or an accessory label affixed for that purpose)." An observation of the medication room refrigerator on 9/29/11 at 3:50PM revealed one opened, undated, multi-dose vial of Tuberculin Purified Protein Derivative (PPD). PPD is a	F 431	3. Measures/systems in place to ensure continued compliance are: The Nurses were in-serviced on 10/10/11 by the DON on the policy for dating vials when opened and destroying any undated vials that have been opened prior to their re-use. Monitoring is being done by inspections of the Medication rooms, refrigerators and carts for undated/expired vials daily by the DON and/or designee weekly x 4 weeks, then bimonthly x 4 weeks then monthly for 4 months. 4. Findings will be reviewed at the monthly QA meetings for 6 months and then quarterly.	10/21/11

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F 431	Continued From page 9 diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part: "A vial of PPD which has been entered and in use for 30 days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results. In an interview on 9/29/11 at 3:53PM, nurse #2 examined the PPD vial and acknowledged it had not been dated when opened. She stated multi-dose vials of PPD expired 28 days after opening. The nurse indicated it was the responsibility of the night shift staff to check the medication room and refrigerator for outdated items. Nurse #2 stated she would remove and discard the undated vial of PPD. In an interview on 9/29/11 at 4:00PM, the Director of Nursing stated the 7PM-7AM nurse on A-hall checked the medication room refrigerator for outdated items. She stated the pharmacy also checked the refrigerator monthly. Her expectation was for the staff to date the vials of PPD when opened and to discard any vials that were found to be undated. The nurse responsible for checking the refrigerator was unavailable for interview.	F 431		

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K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/19/2011 the facility smoke door at the top of the did not close with activation of the fire alarm system. The left side cross corridor door as you are going up the ramp was dragging on the floor and only closed half way. CFR#: 42 CFR 483.70 (a)	K 027	1. The facility smoke door at the top of the assisted living and left side of the corridor were corrected by adjusting door closer and hinges on 10/20/11. 2. All facility smoke doors were examined for appropriate closure with activation of fire alarm. 3. The maintenance director will monitor doors weekly x 4 weeks, then bimonthly x 4 weeks, then monthly x 4 months. 4. Audit results will be discussed monthly at QA meeting for 6 months then quarterly.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/18/2011 the facility has a required accelerator installed on its dry pipe	K 062	1. A new tamper valve switch was installed and wired to protect the system against accidental turn off on 10/25/11. 2. The system will be inspected quarterly by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Smith
TITLE: Administrator
(X6) DATE: 11/4/11

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K 062	Continued From page 1 sprinkler system. This accelerator has a valve that is essential to the sprinkler system. This valve is not currently electrically supervised to protect the system against it being accidently turned off. CFR#: 42 CFR 483.70 (a)	K 062	contracted sprinkler company. 3. The maintenance director will check the system monthly x 6 months. 4. Results will be discussed monthly at QA meeting for 6 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING 02 - BUILDING 02 B. WING ______	10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/19/2011 the facility had a required exit from the main dining room that did not have a solid non slick surface to the public way from that exit. CFR#: 42 CFR 483.70 (a)	K 038	1. On 11/1/11 the contracted installed an asphalt exit to public way. 2. All exits were examined for appropriate exit to public way. 3. Maintenance director will monitor exits quarterly. 4. Results will be discussed at QA meeting quarterly.	11/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Smith | TITLE: Administrator | (X6) DATE: 11/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.